Expert Advisory Committee
Friday April 20, 2012
Healthcentric Advisors
Meeting Minutes

Attendees: John Fleig, Don Wineberg, Elizabeth Lange, Kathryn Shanley, Elaine Jones, Bill Delmage, Jay Raiola, Monica Neronha

I. Call to order – Dan Meuse welcomed the group and advised that in the interest of ensuring we speak to topics that are fully prepared for conversation, the group is going to jump ahead a few topics and begin to discuss the Qualified Health Plans.

II. Presentation – Qualified Health Plans (Slides available upon request]). Hereafter Qualified Health Plans will be referred to as QHP.

Comments/ Questions throughout presentation

a. Dan Meuse: Quick term note that an example of an issuer is United or BCBS – and example of a QHP would be health mate coast to coast.
b. Dan Meuse: The direction and suggestions given do given direction, but do so in a very subjective way. Some caveats to think about before we get into the requirements on QHP's. First, the exchange does not function in a vacuum – RI sees the exchange as an additional marketplace, not the only marketplace. Therefore the standards placed on QHP's may or may not have an impact on those outside the exchange. The other caveat is that there are a whole host of other things that contribute to impacting the structure of health insurance products.
c. Kathryn Shanley: Can the slides be amended to include Qualified Dental Plans?
    i. Dan Meuse: Yes.
d. Kathryn Shanley: Rigid requirements may discourage insurers from competing. My concern, given the size of the market is that no one will want to play. As there already are a lot of regulations, as you alluded to, it is a lot of comply with already, and adding in potentially more, is a challenge. Try to be practical in regulation.
    i. Dan Meuse: Thank you. One of the principles from the Board is flexibility, and that is key.
e. Don Wineberg: why wouldn't the answers to these questions not be answered by the strategic plan?
    i. Dan Meuse: Seeking specificity. We are looking at having the exchange coalesce around specific standards and how it would go about selecting QHP within the next 4-6 months.
    ii. Don Wineberg: Understood - the question then that percolates, given how valuable everyone's time is, and the appearance of the supreme court, and all the work done outside the ACA., why do we stay focused?

iii. Dan Meuse: I appreciate that comment. We are going down a few paths, the first is that we do not want to not do our due diligence because of a potential outcome of a case. Two, there are five or six permutations of how the Supreme Court could rule. Either everything stays status quo, the mandate goes and nothing else -- the mandate and the ancillary protections go -- in those three cases, then we have the exchange and this still works. Or, Medicaid goes and not the mandate; the mandate goes, ancillaries go and Medicaid changes go; the entire law is struck down. We would rather be disappointed that our work went to waste if it gets struck down then not do the work and be far behind if it is upheld. We do appreciate everyone's incredible time commitment to this project.

f. Jay Raiola: To be an effective active purchaser, you need to generate market share. The biggest mistake the exchange can make is to pigeon hole the small business community to say 'one-size-fits-all. Location, education level, needs and wants in terms of what's important to them, and then event within that group there is a diversification of interests. I believe if the exchange mirrors the flexibility of the outside market we can attract more and more businesses through the exchange. Secondly, to be an active purchaser you need an active market, and that works to have an individual mandate. With respect to concerns about the mandate being struck down, why don't we consider having a state individual mandate put on the books by the legislature?
    i. Dan Meuse: The attempt to make sure, especially on the SHOP side that we suggest and that models suggest will be significantly smaller than the individual exchange, will be that we provide a meaningful amount of choice.
    ii. Monica Neronha: There are five products and BCBS is required by law to go through with all clients each of the products to aid in what helps their need. I would expect to see additional products, and because there will be a difference in what the exchange requires. To hit certain price points there will be trade offs. Today, small number of products, fairly limited differences between those, what drives it is what can one afford and what risk can you afford to take. We help navigate similar to what the exchange will do.
g. Elizabeth Lange: Despite great education by the broker, adversarial touch points are at the front desk. Really make sure the education is really pristine, really perfect so that folks understand the budgeting aspect of each plan and the implications of each plan to avoid the adversarial plan.
h. Kathryn Shanley: I think also think about smaller networks. Those that include professional and institutional providers. Not only do they

not want to pay for anything, but they want to be able to go anywhere without realizing the cost.

i. Monica Neronha: There were a few slides on plan management, there were a couple things, i.e. user fee there is a significant user fee on the exchange only applied to QHP; you have the network standards and a big open question – it is unclear on the federal level and certainly in RI what happens if you want to have a tiered network, doesn't include out of state type stuff. Whole idea of standards inside and outside the exchange does give a competitive lead to the potential of excluding certain carriers.
j. John Fleig: Does the executive order set in stone this idea of the active purchaser? Also from United perspective we do not believe that standardizing products or active purchaser model.
    i. Dan Meuse: The how is key. The current proliferation of open networks and wide PPO products does not help this very much. Add on to this the proclivity of many Rhode Islanders that say the quality care can only be found in Boston.
k. Don Wineberg: Limited networks, nothing illegal about them, just a political impossibility.
l. Kathryn Shanley: These are things we do want to do (additional requirements for QHP), we do share these same goals to do that which dictate the how that end up making this burdensome. If the people don't take care of their own health we still have challenges.
    i. Dan Meuse: From a minimalist perspective, if we want the exchange to take as small a role as possibile in the standardization process, if you are an issuer of a QHP then you have to be licensed in RI, and if that's the case then you are subject to the Health Insurance Commissioner affordability standards. Is that enough? I would argue that that there is somewhat of a captive market, for whom they have to buy insurance, and they are getting significant amounts of money to go through the exchange. This is the crux of that discussion, there is leeway here; I would be interested to hear how the providers here see the potential for the exchange to add standards/add requirements to an insurance company that you see would help to improve health.
m. Elaine Jones: It is very complicated. I think business as usual isn't working, it is why we are doing this, I do not know how we make that change but we start by this law passing, the patient part is huge, being healthy people, cannot quite force them to do that. One way to indirectly guide is to focus on adding in the healthy things, quality, prevention, wellness. Do things now that will save money down the line. I think the exchange should play an active role in health. Setting up guidelines for what is a good healthcare product.
n. Elizabeth Lange: the tension is we are talking about say 65,000 people and we have a state of one million people. What is interesting to me

about the discussion around EHB were the number of people we had not seen before, and all are jockeying for positions. How do we do all this and value all professionals. Until we can all be grownups, that is the case.

o. Bill Delmage: I agree, on Monday everyone came out for EHB; If you compare health insurance to car insurance, we are paying for windshield wipers, for mufflers – we almost set ourselves up for this. I see the exchange as part of that education piece to redirect and teach people why they have to live healthier lives. In the state of RI, if you look at our population, 1/3 is either pre-diabetic or diabetic; Imagine the exchange that has all these regulations, now add in the reward piece – doing everything right, but give it the ability to be the carrot. Maybe the exchange is the carrot that says I have now met the minimum criteria.
p. John Fleig: I agree with Bill's points. There are wellness incentives; this is not a magic bullet, and it's just not going to do it alone - wellness programs out there can be increased or expanded. Now, in terms of cost containment, I am not sure what that means.
    i. Dan Meuse: First of all the way that the EO came out does not necessarily drive us towards a model of setting a price ceiling, rather more towards negotiating on price.
    ii. John Fleig: I don't see a discussion on the underlying cost of health care. Where is it coming from? Premiums keep going up and we don't see why.
q. Elizabeth Lange: Incentivizing quality of care – to me that seems that I as a physician get the reward for ensuring my diabetic patient takes meds, sees eye doctor, etc. Need to develop strong wellness programs and personal incentives for the patients. If we can get patients more engaged through this system.
    i. Elaine Jones: And I think the consequences part is another piece that is missing – there is no disincentive.
    ii. Don Wineberg: I also would like to make a note that I feel the exchange can only succeed by incrementally providing less expensive products, etc. Baby steps will allow this to move forward successfully.
r. Dan Meuse: State wellness program? Take a similar state health employees wellness rewards programs but apply it on a larger scale?
    i. Monica Neronha: Sounds great, but how do we pay for it. No such thing as free, it has to be built into premium rates. Supporting wellness programs is easy, supporting it with a capped premium rate is a different question.
    ii. Dan Meuse: We all have cell phones, and say it only costs 150.00, it actually costs 250, but with a 100.00 mail in rebate the cost is down. Perhaps challenge us to think through way like that. Considering incremental change, a potential to move in small processes. If people like the ability to say this is how

much it costs but I can earn something back, even if it is small, the underlying post rebate cost .

iii. Monica Neronha: We do have a product like that in the direct pay product in which they have an opportunity to earn back 10% of their premium, and less than 10% of those who are enrolled take part in that program.

s. Bill Delmage: Instead of 54 million to reinvent what BCBS and United and Tufts already do, use a significant budget to educate. There is a population of folks who sit there who will not work overtime, who will not earn more as they lose all these benefits if they earn over a certain dollar amount.

t. Kathryn Shanley: The other thing is that a lot of people do not file for the rebate and that is why they have them – they make money on them. People will not file.

u. Elaine Jones: For my business I looked at the wellness plans that were offered, I thought it sounded great, but in the end found it too complicated.

v. Monica Neronha: Going back to the Supreme Court conversation, I think we need to be careful with our presumptions. Moving forward and assuming that the mandate is struck down and the subsidy is maintained is a dangerous assumption and just ask that we keep that in the back of our heads. Subsidy is a critical piece.

w. Dan Meuse: One of the things we are having consultants look at is potential contingencies and effects to ensure we are not flat footed.

III. Public Comment – No additional Comment Made

IV. Adjourn – Next meeting May 8, 2012.